EXHIBIT "6"

P.O. Box 830847
Miami FL 33283-0847

IF PAYING BY VISA, MASTERCARD, DISCOVER OR AMERICAN EXPRESS, FILL OUT BELOW
CHECK CARD USING FOR PAYMENT

CARD NUMBER

SIGNATURE | EXP. DATE

STATEMENT DATE	PAY THIS AMOUNT	ACCT. #
11/25/24	$ 445.80	17244869-1

SHOW AMOUNT PAID HERE $

☐ Please check box if address is incorrect or insurance information has changed, and indicate change(s) on reverse side.

KEN55C 5145943 655130604

Heriberto Valiente
4214 SW 164TH PATH
MIAMI FL 33185-5290

Kendall Credit
and Business Service, Inc.
P.O. Box 404665
Atlanta, GA 30384-4665

00017244869100000445802010O7

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

STATEMENT

**** Please include your account number on all forms of payment ****

Si necesita una interpretacion de esta carta, por favor comuniquese con nuestra oficina.

PLEASE CALL Darlene Gingras AT (786) 594-6688 EXT. 46666

Creditor: Baptist Hospital
Debtor: Valiente,Heriberto
Account No.: 17244869-1
Service Date: 07/20/24
Amount Due: $445.80

You have not responded to our first collection notice, therefore we will now pursue full collection efforts. To avoid further collection efforts, send your payment in full to our office.

If you are unable to pay this amount in full now, please call us today and make an acceptable arrangement. Do not delay this important matter which requires your attention.

**** Please include your account number on all forms of payment ****

***** To pay online go to: https://billpay.baptisthealth.net *****

Federal law requires us to inform you that this is an attempt to collect a debt and any information obtained will be used for that purpose.

This communication is from a debt collector.

CHANGE OF ADDRESS OR HEALTH INSURANCE INFORMATION

Heriberto Vallente
17244869-1

If you have new health insurance or a new address, please enter the information below.

NEW ADDRESS	CITY	STATE	ZIP CODE
NEW PHONE#		NEW EMAIL ADDRESS	
POLICY HOLDER'S NAME/RELATIONSHIP TO PATIENT		POLICY ID # GROUP #	
EFFECTIVE DATE	BIRTH DATE OF INSURED	HMO/PPO/OTHER	INSURANCE PHONE #
IF GROUP INSURANCE, NAME OF GROUP (EMPLOYER, UNION/ASSOCIATION)			
INSURANCE COMPANY NAME		INSURANCE ADDRESS	
EMPLOYER		EMPLOYER ADDRESS	